STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008032	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY'S FAMILY CARE HOME #3	106 HARMON STREET AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 03/31/26.	C 000		
C 074	10A NCAC 13G .0315 (a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) A family care home shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure the floor coverings were clean and in good repair including flooring that was ripped and torn in the hallways. The findings are: Review of a Division of Health Service Regulation (DHSR) construction survey conducted on 01/14/26 revealed: -It was observed that the flooring in the foyer gives when walked on. -The deficiency was previously cited during their 2023 biennial survey and action had not been taken to address the deficiency. Review of the Environmental Health Inspection of Residential Care Facilities conducted 02/27/26 revealed: -There was 1 demerit awarded for floors and carpets in good repair.	C 074		

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C 074	Continued From page 1 -There were many soft and uneven spots in the floors throughout the home. -Flooring was torn in the hallway. Observation of staff on 03/31/26 at 10:15am revealed her foot was caught on torn linoleum in the hallway outside the kitchen and she stumbled without falling. Observation of the flooring on 03/31/26 at 10:55am revealed: -There was a tear linoleum approximately one foot in length and lifted up from the subfloor beneath in the hallway outside the kitchen. -The floor was soft when stepped on at the toe plate in the doorway leading from the hallway into the TV room and the linoleum was torn on either side. Interview with a resident on 03/31/26 at 10:45am revealed: -He had stumbled over the cracks in the flooring but had not fallen. -Everyone at the facility had stumbled on the flooring but they all tried to walk over the tears. -He could not remember how long the flooring had been torn in the areas. Interview with the Supervisor-in-Charge (SIC) on 03/31/26 at 1:55pm revealed: -The flooring had been torn for approximately 2 weeks. -She stumbled on the floor that morning and knew a resident had stumbled in the past but no one had fallen. -The Administrator was aware and someone was scheduled to make repairs. Interview with the Administrator on 03/31/26 at 2:36pm revealed:	C 074		

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C 074	Continued From page 2 -Construction had mentioned issues with the flooring when they were out for their survey. -She had trouble finding someone to come out to do the work but her family member, who was a contractor, was coming out to do repairs to the flooring later in the week.	C 074		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the home and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (#3) FL-2 was updated annually. The findings are: Review of Resident #3's FL-2 dated 11/07/24	C 203		

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C 203	Continued From page 3	C 203		

revealed:
-Diagnoses included diabetes Type II, traumatic brain injury and sleep apnea.
-He was ambulatory.
-There was no information regarding orientation status.

Review of Resident #3's Resident Register revealed he was admitted on 09/24/21.

Review of Resident #3's care plan dated 11/13/24 revealed:
-Resident #2 had a history of developmental disability.
-He was forgetful and needed reminders.
-He was independent with all activities of daily living.

Review of Resident #3's record on 03/31/26 revealed there was no FL-2 completed in 2025 or 2026.

Interview with the Supervisor-in-Charge (SIC) on 03/31/26 at 1:55pm revealed:
-She was not aware Resident #3 did not have a current FL-2.
-The Administrator was responsible for ensuring resident FL-2's were current and completed annually.

Interview with the Administrator on 03/31/26 at 2:36pm revealed:
-She was aware FL-2s needed to be completed on each resident annually.
-She and the SIC were responsible for ensuring FL-2s were completed annually.
-She was not aware Resident #3's FL-2 was not current.
-They placed due dates for each resident FL-2 on a calendar but it was not placed on the calendar

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C 203	Continued From page 4 for Resident #3 as it should have been. -It was an oversight that Resident #3's FL-2 had not been completed. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/31/26 at 12:03pm was unsuccessful.	C 203		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of	C 236		

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C 236	Continued From page 5 this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#3) had an annual care plan that was completed to include the level of assistance required and frequency tasks were to be provided to address the residents needs. The findings are: Review of Resident #3's FL-2 dated 11/07/24 revealed: -Diagnoses included diabetes Type II, traumatic brain injury and sleep apnea. -He was ambulatory. -There was no information regarding orientation status. Review of Resident #3's Resident Register revealed he was admitted on 09/24/21. Review of Resident #3's care plan dated 11/13/24	C 236		

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C 236	Continued From page 6 revealed: -Resident #2 had a history of developmental disability. -He was forgetful and needed reminders. -He was independent with all activities of daily living. Review of Resident #3's record on 03/31/26 revealed there was no care plan completed in 2025 or 2026. Interview with the Supervisor-in-Charge (SIC) on 03/31/26 at 1:55pm revealed: -She was not aware Resident #3 did not have a current care plan. -The Administrator was responsible for ensuring resident care plans were current and completed annually. Interview with the Administrator on 03/31/26 at 2:36pm revealed: -She and the SIC were responsible for ensuring care plan were completed annually. -She was not aware Resident #3's care plan was not current. -They placed due dates for each resident care plan on a calendar but it was not placed on the calendar for Resident #3 as it should have been. -It was an oversight that Resident #3's care plan had not been completed. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/31/26 at 12:03pm was unsuccessful.	C 236		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health	C 252		

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C 252	Continued From page 7 Professional Support (a) The facility shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan, and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, TED hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy. For the purpose of this Rule, "well-established colostomy or ileostomy" means having a healed surgical site without sutures or drainage; (10)care for pressure ulcers, up to and including a Stage II pressure ulcer, which is a superficial ulcer presenting as an abrasion, blister, or shallow crater; (11)inhalation medication by machine; (12)forcing and restricting fluids; (13)maintaining accurate intake and output data; (14)medication administration through a well-established gastrostomy feeding tube. For	C 252		

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C 252	Continued From page 8 the purpose of this Rule, "well-established gastrostomy feeding tube" means having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established; (15)medication administration through subcutaneous injection in accordance with Rule .1004(q) except for anticoagulant medications; (16)oxygen administration and monitoring; (17)the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18)oral suctioning; (19)care of well-established tracheostomy, not to include endotracheal suctioning. For the purpose of this Rule, "well-established tracheostomy" means the stoma is well-healed and the airway is patent; (20)administering and monitoring of tube feedings through a well-established gastrostomy feeding tube in accordance with Subparagraph (a)(14) of this Rule; (21)the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22)application of prescribed heat therapy; (23)application and removal of prosthetic devices except as used in post-operative treatment for shaping of the extremity; (24)ambulation using assistive devices that requires physical assistance; (25)range of motion exercises; (26)any other prescribed physical or occupational therapy; (27)transferring semi-ambulatory or non-ambulatory residents; or (28)nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that Act in 21 NCAC 36.	C 252		

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C 252	Continued From page 9	C 252		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 1 of 1 residents (#3) including the identified tasks fingerstick blood sugar (FSBS) and use of a CPAP.

The findings are:

Review of Resident #3's FL-2 dated 11/07/24 revealed:
-Diagnoses included diabetes Type II, traumatic brain injury and sleep apnea.
-He was ambulatory.
-There was no information regarding orientation status.

Review of Resident #3's Resident Register revealed he was admitted on 09/24/21.

Review of Resident #3's care plan dated 11/13/24 revealed:
-Resident #2 had a history of developmental disability.
-He was forgetful and needed reminders.
-He was independent with all activities of daily living.

Review of Resident #3's record revealed there were no Licensed Health Professional Support (LHPS) evaluations available for review.

1.Review of Resident #3's after visit summary

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C 252	Continued From page 10 dated 01/21/26 revealed: -He was seen by neurology for obstructive sleep apnea. -He was discharged with home supplies CPAP replacement supplies. Observation of Resident #3's bedroom on 03/31/26 at 10:45am revealed: -There was a continuous positive airway pressure (CPAP) machine sitting on the bedside table. -The facemask for the CPAP was hung on the headboard. Interview with Resident #3 on 03/31/26 at 10:45am revealed: -He had sleep apnea and used the CPAP machine each night. -He did not know when he was first ordered the CPAP. -He was independent with using the CPAP and did not require staff assistance. -Staff checked his finger stick blood sugar twice a day. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/31/26 at 12:03pm was unsuccessful. Refer to interview with the Supervisor-in-Charge (SIC) on 03/31/26 at 1:55pm. Refer to interview with the Administrator on 03/31/26 at 2:36pm. 2.Review of Resident #3's medication administration records for January 2026 revealed: -There was and electronic entry for blood sugar checks four times a day for monitoring. -The blood sugar checks were scheduled for 8:00am, 12:00pm, 5:00pm and 8:00pm.	C 252		

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C 252	Continued From page 11 -There were blood sugar checks documented each day at 8:00am and 8:00pm on 01/01/26 through 01/31/26. -There were no blood sugar checks documented each day at 12:00pm and 5:00pm on 01/01/26 through 01/31/26. Review of Resident #3's medication administration records for February 2026 revealed: -There was and electronic entry for blood sugar checks four times a day for monitoring. -The blood sugar checks were scheduled for 8:00am, 12:00pm, 5:00pm and 8:00pm. -There were blood sugar checks documented each day at 8:00am and 8:00pm on 02/01/26 through 02/28/26. -There were no blood sugar checks documented each day at 12:00pm and 5:00pm on 02/01/26 through 02/28/26. Review of Resident #3's medication administration records for March 2026 revealed: -There was and electronic entry for blood sugar checks four times a day for monitoring. -The blood sugar checks were scheduled for 8:00am, 12:00pm, 5:00pm and 8:00pm. -There were blood sugar checks documented each day at 8:00am and 8:00pm on 03/01/26 through 03/30/26. -There were blood sugar checks documented at 8:00am on 03/31/26. -There were no blood sugar checks documented each day at 12:00pm and 5:00pm on 01/01/26 through 03/31/26. Interview with Resident #3 on 03/31/26 at 10:45am revealed staff checked his finger stick blood sugar twice a day.	C 252		

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C 252	Continued From page 12 Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 03/31/26 at 12:59pm revealed they received an order for Resident #3 on 10/04/24 to have finger stick blood sugar checks completed four times daily. Attempted telephone interview with Resident #3's primary care provider (PCP) on 03/31/26 at 12:03pm was unsuccessful. Refer to interview with the Supervisor-in-Charge (SIC) on 03/31/26 at 1:55pm. Refer to interview with the Administrator on 03/31/26 at 2:36pm. _____ Interview with the Supervisor-in-Charge (SIC) on 03/31/26 at 1:55pm revealed: -There was no nurse that came to the facility to complete an assessment for Licensed Health Professional Support (LHPS) quarterly. -There had been no LHPS nurse in since March 2025. -The Administrator was responsible for ensuring LHPS evaluations were completed quarterly. Interview with the Administrator on 03/31/26 at 2:36pm revealed: -There used to be a Registered Nurse that came in quarterly and she did not know why she had not come in. -She was not aware Resident #3 had not had quarterly LHPS evaluations completed and had not reached out to ensure they were completed. -She reviewed resident records quarterly and it was an oversight that Resident #3's LHPS evaluations were missed.	C 252		

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C 315	Continued From page 13	C 315		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure clarification of medication and treatment orders for 1 of 3 sampled residents (#3) including orders for fingerstick blood sugar checks. The findings are: Review of Resident #3's FL-2 dated 11/07/24 revealed: -Diagnoses included diabetes Type II, traumatic brain injury and sleep apnea. -He was ambulatory. -There was no information regarding orientation status. -There was no order for fingerstick blood sugar checks. Review of Resident #3's medication administration records for January 2026 revealed:	C 315		

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CHERRY'S FAMILY CARE HOME #3	106 HARMON STREET AULANDER, NC 27805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 315	Continued From page 14 -There was and electronic entry for blood sugar checks four times a day for monitoring. -The blood sugar checks were scheduled for 8:00am, 12:00pm, 5:00pm and 8:00pm. -There were blood sugar checks documented each day at 8:00am and 8:00pm on 01/01/26 through 01/31/26. -There were no blood sugar checks documented each day at 12:00pm and 5:00pm on 01/01/26 through 01/31/26. Review of Resident #3's medication administration records for February 2026 revealed: -There was and electronic entry for blood sugar checks four times a day for monitoring. -The blood sugar checks were scheduled for 8:00am, 12:00pm, 5:00pm and 8:00pm. -There were blood sugar checks documented each day at 8:00am and 8:00pm on 02/01/26 through 02/28/26. -There were no blood sugar checks documented each day at 12:00pm and 5:00pm on 02/01/26 through 02/28/26. Review of Resident #3's medication administration records for March 2026 revealed: -There was and electronic entry for blood sugar checks four times a day for monitoring. -The blood sugar checks were scheduled for 8:00am, 12:00pm, 5:00pm and 8:00pm. -There were blood sugar checks documented each day at 8:00am and 8:00pm on 03/01/26 through 03/30/26. -There were blood sugar checks documented at 8:00am on 03/31/26. -There were no blood sugar checks documented each day at 12:00pm and 5:00pm on 01/01/26 through 03/31/26.	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008032	A. BUILDING: _____ B. WING _____	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 315	Continued From page 15 Interview with Resident #3 on 03/31/26 at 10:45am revealed staff checked his finger stick blood sugar twice a day. Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 03/31/26 at 12:59pm revealed they received an order for Resident #3 on 10/04/24 to have finger stick blood sugar checks completed four times daily. Interview with the Supervisor-in-Charge (SIC) on 03/31/26 at 1:55pm revealed: -She completed FSBS twice daily for Resident #3. -She was aware the FSBS were entered onto the MAR for four times daily. -Resident #3 ran out of supplies when FSBS were done four times each day. -She spoke with Resident #3's primary care provider (PCP) regarding his blood sugar checks. -The PCP told her FSBS only needed to be completed twice daily. -There was no documentation of the conversation with the primary care provider and no order was written for twice daily FSBS checks. Interview with the Administrator on 03/31/26 at 2:36pm revealed: -She reviewed resident records quarterly but was not aware Resident #3's FSBS checks were completed twice daily instead of four times daily. -The SIC should have contacted the PCP regarding any concerns and a new order should have been written if frequency of FSBS checks changed. -She and the SIC were responsible for clarifying orders as needed. Attempted telephone interview with Resident #3's primary care provider on 03/31/26 at 12:03pm was unsuccessful.	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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